Paso Robles Joint Unified School District
800 Niblick Road
Paso Robles, CA 93446

Seizure Care Plan

STUDENT INFORMATION

Date: _____

School Site: _____

Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Contact Phone: _____

Treating Physician: _____ Physician Phone: _____

Significant Medical History: _____

Seizure Information:

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

Basic First Aid: Care and Comfort:

Does student need to leave the classroom after a seizure? ☐ Yes ☐ No

If Yes, describe the process for returning student to classroom:

Basic Seizure First Aid:

- Stay Calm & Track Time
- Keep Child Safe
- Do Not Restrain
- Do Not Put Anything in the Mouth
- Stay with Child Until Fully Conscious
- Records Seizure in Log
- Protect Head
- Keep Airway Open/Watch Breathing
- Turn Child on Side

Emergency Response:

A "Seizure Emergency" for this student is defined as:

Seizure Emergency Protocol: (check all that apply and clarify below below)

☐ Contact Site LVN:

☐ Notify Parent or Emergency Contact:

☐ Notify the Physician:

☐ Administer Emergency Medications as Indicated Below

☐ Other:

Treatment Protocol During School Hours: (include daily and emergency medications)

Medication	Dosage and Time of Day Given	Common Side Effects/Special Instructions

Special Considerations/Safety Precautions:

Parent Signature: _____ Date: _____

Physician Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

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